of the perinephritic abscess palpation will usually determine the condition. Although the existence of an acute perinephritic abscess may easily be determined, chronic perinephritic abscess may remain unrecognized until revealed at operation.

It may be difficult to differentiate between a subdiaphragmatic or retroperitoneal abscess and true perinephritic abscess. As a rule, symptoms of the original lesion and a more general invasion of the tissues will differentiate the two conditions. The data obtained through urinalysis, cystoscopic examination, bacteriologic examination, renal functional tests and the roentgenogram are often of considerable aid in differentiation.

Results. Of the 67 patients operated on at the Mayo Clinic, two (three per cent.) died as the result of the operation. Three other patients were reported dead at three, seven and twelve months, respectively, after operation.

The subsequent course was ascertained in 51 of the remaining patients. In 18 of this number the wound had healed in less than a month after operation. Of the remaining patients, 16 continued to drain for two months, six drained for three months, and three drained as long as six months after operation. The fistula persists to the present date in four patients all of whom drained longer than six months. In two of these patients an etiologic renal lesion was ascertained at the time of drainage and subsequently nephrectomy was advised. In the other two no evidence of renal lesion was discovered on clinical examination, however, the more recent clinical tests were not employed. One of these patients, drained one and one-half years ago, has returned with cystoscopic evidence of an etiologic renal lesion not previously discovered.

The question is frequently raised at operation whether immediate nephrectomy or drainage of the abscess alone is indicated. In the presence of a large fluctuating abscess and marked physical weakness drainage will suffice; if, however, evidence of considerable renal involvement has been ascertained, immediate nephrectomy as well as drainage is to be preferred when possible. The practical importance of previously ascertaining the underlying renal condition is self-evident.

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THE NEED OF PSYCHOPATHIC HOSPITALS IN LARGE CITIES.

(With Illustrative Cases.)

By HAROLD W. WRIGHT, M. D., San Francisco.

The following cases have been selected from several hundred which the writer had the privilege of observing intimately in the psychopathic department of Bellevue Hospital, New York. They represent types of mental disorders which come to that hospital in large numbers every month and which recover to the previous degree of normality in from one to six weeks.

They are classified as "Constitutional Inferiority," "Undifferentiated Depression," "Depressive Hallucinosis," "Acute Hallucinosis" (cause specified), "Allied to Manic-Depressive Psychosis," "Toxic Exhaustive Delirium," "Psycho-Neurosis" and "Hysteria," "Hallucinatory Paranoid Condition," etc.

They come from all walks in life; some are committed by magistrates after having come into conflict with the law; none of them require commitment to an asylum, and they more than justify the establishment of psychopathic departments in general hospitals, for they often require the aid of expert consultation with other departments of medicine. They illustrate particularly the value of a psychopathic hospital for acute cases as a factor in social economy, to say nothing of its value to the individual.

Case 1. Bromide Intoxication Following Simple Mental Depression. A nurse of forty-five with a history of chronic mental depression of several years' standing for which sodium bromide was used more or less continually while keeping at work. The patient was admitted in a state of delirium of the occupational type. She was loquacious, restless and distracted easily by sounds. Her spontaneous remarks and her replies to questions showed flight of ideas. She was disoriented and unable to give a coherent account of herself. She indulged in much fabrication in a reminiscent way, was very confused for recent events, easily made fearful and reacted to many illusions of sight and hearing. Her speech showed very marked paraphasia. Physically she was well nourished, had an acneiform eruption; the pupils were sluggish in reacting to light, and the tendon reflexes were exaggerated; there was marked defect in the sense of touch and pain, a fine tremor of the tongue and hands. Lumbar puncture gave negative results. After three days the patient was found to be partially oriented, her attention could be held for brief periods and the paraphasia was less noticeable. She continued to show fabrication of memory in trying to give an account of herself. Gradually the delirium subsided and in four weeks from the date of admission the patient was discharged entirely recovered. Had she not been given the advantage of prolonged observation in the psychopathic ward she would have been committed to an asylum, and because of the crowded conditions of such institutions her alienation from society with the stigma at present attached thereto would have been much more prolonged.

Case 2. Psychoneurosis With Hallucinatory Paranoid Complex. The patient was a divorced woman forty years of age. Her divorce occurred ten years ago and for several years had been in love with a married man who was unable to legally marry her. For three years past the patient had been very "nervous" and unable to apply herself to her usual work of a saleswoman. For a month or more she had thought that a woman in the apartment above her, a woman with whom she had had no relations whatever, friendly or otherwise, was talking to her and directing her thoughts, that she was under the control of this woman. On the day before admission the patient went to this woman and accused the latter of exerting an influence over her, and of reading her mind; the woman became alarmed and had a warrant served on the patient. When examined in the hospital she expressed regret over her conduct and said she had made a mistake. She was very uneasy in manner, at times tearful, but spoke coherently and answered questions intelligently although evasively when ques-

tioned about her hallucinations. Later she admitted that she was very much in love with the man before mentioned, that he was constantly in her thoughts, but that the legal and moral obstacles in the way of her attachment were insurmountable and that she felt that other people must know of her guilty love. After a week of observation the patient showed no further hallucinosis, was less agitated although still depressed; she was discharged against advice to her relatives, no system of delusions having been revealed. This was evidently a border line case and the patient may yet be committed; however, she can, through the cooperation of a visiting nurse, be kept under observation and in touch with the hospital for some time to come.

Case 3. Transient Depressive Hallucinosis. A young Russian girl gave birth to an illegitimate child eleven weeks before being admitted to the hospital. Eight weeks after childbirth she became very quiet and melancholy and showed suspicion of the medicine her private physician prescribed; also at that time she began to fancy that she heard people say that harm would come to her if she did not leave her lodging place. She was admitted in a state of depression with evidence of being in fear, but would say nothing when questioned. In two days she was bright and talkative, but forty-eight hours later she had a recurrence of fear with hallucinations in reaction to which she became mute, staring fixedly and being inaccessible to questions. This condition subsided within twenty-four hours and on recovery the patient had no recollection of the attack. There was no physical disorder.

This patient might easily have been rushed to an asylum, the fact that she was only a somewhat weak-minded ignorant girl who had not yet adjusted herself to a difficult situation being overlooked.

Case 4. Simple Depression Undifferentiated. A young Italian girl ten months post-partum with an illegitimate child and deserted by her lover tried to jump from the roof of her dwelling. She had previously been under treatment for tuberculosis. Concern over the means of support for herself and child, combined with ill-health and the feeling of disgrace, drove her to attempt suicide. She was very depressed and retarded in thought, but two weeks after admission she became more cheerful, her improvement being enhanced by the efforts of the Social Service Department in her behalf. She was transferred to the medical ward and later to a sanitarium for incipient tuberculosis; her child was also provided for without the patient being deprived the privilege of assuming the care of it later on. This case illustrates the great need of Social Service workers in connection with a psychopathic hospital.

Case 5. Depressive Hallucinosis With Complete Recovery. An Austrian housemaid of thirty-eight years had been very efficient until three months previous to admission, when she became hypersensitive about a matter of trivial dishonesty on her part. A few weeks later she thought she heard some one in church say that her mistress would have her arrested; a day or two later she ran out of the house in the middle of the night crying out that policemen were in her room. On admission she was depressed and agitated, complained of noises in her ears, but gave a coherent account of herself. No further hallucinations occurred in the hospital; she gradually became cheerful and acquired correct insight into the previous morbid condition and was ready for discharge after ten days. There was no alcoholism or other causative factor of a toxic nature in this case; the patient was an intelligent but uneducated and superstitious woman. She was taken again into the employ of her former mistress. Had she been once adjudged insane she would have had great difficulty in getting work again.

Case 6. Hysteria With Paranoic Type of Reaction to Fear. A highly intelligent girl of sixteen years fell through a trap-door at her place of employment and slightly sprained her ankle. Her mother began suit for damages against the girl's employer and frequently talked about the suit in the presence of her daughter, abusing her employer for his reluctance in settling the claim. The patient then began to fear that her employer would do her some harm. A little later while at a theatre the patient was spoken to in a familiar way by a strange man whom she decided was an agent of her employer. She then took a position in a hospital as a ward maid in order, as she said, to be in a safe place. While working in this hospital her foot, which had recovered entirely from the sprain, suddenly assumed a rigid position of equinovarus, with loss of ability to bear weight upon it. A plaster cast was unfortunately applied, the condition not being properly diagnosed as hysterical contracture. The patient then began to fear and to believe that she was permanently crippled; for this reason she took oxalic acid with suicidal intention, and was sent to the psychopathic hospital. There she was at first depressed and uncommunicative; when spoken to she assumed a shrinking attitude of fear. Later the patient admitted that she was worrying over a love affair about which she was afraid to tell her mother. After a week of observation the patient became much more cheerful, seemed normally sociable, and the deformity of her foot disappeared a few days after the removal of the plaster cast and assurances of a speedy recovery. She was then discharged. A week later she ran away from home and was found in a state of excitement which soon subsided. Her mother was then urged to bring her to the psychopathic hospital again for further observation and psycho-analysis, but refused. This case was not one for commitment to an insane hospital, but did require prolonged observation and analysis with occupational treatment under the protection of the hospital or as an out-patient under the supervision of a social worker.

Case 7. Neurasthenic Depression Allied to Manic Depressive Insanity. A Russian Jewess of twenty-six years who had but recently emigrated to America after many difficulties and hardships because of being associated with revolutionists. She had formerly lived in a quiet Russian village and had planned to live in the country, but instead was obliged to accept work in the New York Ghetto, in a badly ventilated sweat-shop for small wages. She was also obliged to aid in the support of relatives. These conditions, combined with worry over finances and disappointment with her new surroundings, gradually culminated in a condition of despair accompanied by headaches, great fatigue and inability to make decisions; the fear of going insane also developed and was a prominent factor. She was brought to the psychopathic hospital because of an outbreak of extreme agitation and inability to look after herself. A few days in the hospital resulted in a marked improvement, and by the aid of the Social Service Department the patient was sent to a convalescent home outside of the city.

These cases are typical of many which are found in every large city and they are often very difficult to classify. There are other types of temporary mental disorder which require the services of those who are expert in both physical and mental diagnosis. I refer to the cases of atypical typhoid fever, pneumonia, valvular heart disease and toxic exhaustive conditions. When these diseases occur in persons of unstable mental constitution they result in mild delirium with stupor, or in a more active delirium with hallucinations, or simply in a retarded and confused condition of the mind with vague and changing delusions and occasional illu-

sions of sight and sound. Very often in these patients the physical disorder which is responsible for the psychic state is overlooked and masked, because of the prominence of the mental symptoms. Not infrequently the mental symptoms are the first to attract notice. Such patients have been sent to state hospitals for the insane before adequate time for proper diagnosis had elapsed, and their chances for recovery from the physical diseases much impaired thereby, to say nothing of the subsequent effect on the patients' minds on recovery to normal consciousness. The same remarks apply to many cases of puerperal psychosis, which are but transitory excitements with confusion of the apperceptive faculties accompanied by infection or toxemia. The writer has seen such patients recover inside of a month and then be detained many weeks among the acute and chronic insane because of the legal formalities required in custodial institutions before the patient could be discharged. So long as the lay mind regards the insane hospital and its inmates with that uncanny feeling and the idea that such patients are forever stigmatized, so long will serious mental shock and injustice be needlessly inflicted upon sick people.

Finally there is another class of unfortunates to be considered, persons who are not menaced by commitment to institutions for the insane, but who are themselves a menace to society because of not being so committed at the proper time. I refer to various types of offenders against the law of the land. Some are distinctly feeble-minded and commit offenses when made the tools of the more clever. Others are incipient cases of paranoia, dementia precox, acute mania, alcoholic psychosis or general paralysis; others are the so-called "constitutional inferiors" who lack balance in respect to their emotions and judgment. Oftentimes when these people offend against the law they are given temporary sentences to jail, workhouse or penitentiary, only to be set free upon society again without any estimate of the mental status having been made. They to a large extent compose the class of "recividists." These cases illustrate again the need of hospitals for the prolonged observation of border-line mental disorders, where co-operation can be had with the general hospital wards, with organizations for social service, with the public schools, the home, and with courts of justice.

Should such a hospital be separate and distinct in its organization, and should it be under the administration of the municipality or under the state? This will depend somewhat upon local conditions. Such hospitals have already been established by the state in Boston and in Michigan and are resorted to by all classes of people. In cities where there exists a state university medical school, a state psychopathic hospital would seem to be an ideal arrangement, for it would then be brought into close touch with all citizens. Where local conditions or financial difficulties prevent such an affiliation, the psychopathic hospital should be a part of the largest general hospital of the city and should be affiliated with a medical school wherever such exists. At the same time it should be at sufficient distance from the other wards of the general hospital to prevent contact of psychopathic patients with other patients. While it should have the atmosphere of a hospital for the sick, this atmosphere should be somewhat modified to the extent of providing more recreational and occupational facilities for those patients who do not require to be in bed than is usually found in general hospitals; this is of great importance in making the detention of patients agreeable and voluntary.

Those patients whose illnesses are more acute and troublesome should be in a pavilion separated from the ambulatory patients and there should be separate rooms for these. This pavilion should be divided into a department for noisy patients and a department for quiet patients; the walls of the rooms in the former department should be soundproof; noisy, resistive or assaultive patients should have special nurses detailed to care for them only, and this department should be equipped with the best appliances for hydro-therapy, especially the continuous warm bath. Except in the rooms for noisy or resistive patients, there should be no bars on windows; they are unnecessary in such an institution, with the above exception, and add to rather than lessen the difficulty of detaining patients quietly. There is no reason why, under proper supervision and a sympathetic, intelligent staff, patients should not be as contented and remain as voluntarily as in other hospitals. While such a scheme implies considerable initial expense, and a larger staff of nurses than is usually found in such institutions, the expense is less in the long run by such a method because the results to the patients, and therefore to the community, are vastly better.

Should the hospital be part of the County Hospital? Not if the county hospital is identified with the care of the pauper only, because all social classes of patients will need the protection of the psychopathic hospital and it should be the first resort rather than the last for them. The family physician of any patient should be encouraged to keep in touch with his patient after admission to the psychopathic hospital, for in this way the neglected field of psychiatry could be actively cultivated by the general practitioner.

As to the commitment of patients found definitely and chronically insane: Where the law requires the production of the patient in court, and an open hearing court-room facilities of as informal a kind as possible should be provided within the institution itself, and every effort should be made to keep out of the proceedings all aspects of a punitive nature and to give them the atmosphere of medical consultations. This is now done in some institutions, the patient having all of his legal rights safeguarded and yet not subjected to the strain of making a defense against a technical charge of a misdemeanor, in public. Where the law does not require such formal hearings, the judge should visit the patients with the doctor in an informal manner. Finally the institution or department should have an out-patient clinic as an integral part of it. In this clinic many cases could be handled indefinitely before deciding upon hospital care, and those patients subsequently discharged from the psycho-

pathic hospital or from the state hospitals could be followed up by being referred to the out-patient department just as in other branches of clinical work.

NOTE—For the privilege of reporting the above cases the writer is indebted to Dr. M. S. Gregory, alienist at Bellevue Hospital, New York City.

ARE WE MAKING PROGRESS IN THE EARLY RECOGNITION OF TUBERCULOSIS?*

By GEORGE H. EVANS, M. D., San Francisco.

The interrogative character of the title of this paper was suggested by the recent visit to my office of a woman of apparently healthy appearance, who upbraided me for having made an erroneous diagnosis. She had, according to her statement, been to a number of physicians subsequent to my examination, all of whom had told her there was nothing the matter with her lungs. In one instance this had been "proven" by X-ray examination. This woman was probably sincere in her opinion that I had made a mistake; just as sincere as were undoubtedly those who drew their diagnostic conclusions solely from the physical examination.

Five months before she presented herself to me with the following history: She was 35 years of age, married and had had a constant cough with some fever for a month. She had lost practically no weight during this time but was 25 lbs. below her highest recorded weight. Her maternal grandmother and two of her own brothers had died of pulmonary tuberculosis. There had been a long and continuous house contact. She was of a decidedly nervous temperament, had naturally always feared tuberculosis. She had had a slight cough since childhood. Was subject to sore throat as a child, had whooping cough, and at 18 years of age had measles.

A careful correlation of the history and symptomatology here described certainly cannot justify one in definitely pronouncing this woman non-tuberculous, even though marked physical signs had been absent. She was apparently fairly healthy in appearance, but no more so than can be seen in a considerable proportion of the inmates of tuberculosis sanatoria, or among those attending tuberculosis clinics. The emaciated consumptive, the individual presenting the classical phthisical habitus is the advanced, hopeless consumptive, not the patient with early tuberculosis which the profession is charged with recognizing.

She presented a symmetrical chest with diminished excursion on the right side and definite spasm of the muscles over the apex in front and behind. There was dullness in front down to the second rib on the right, and a corresponding dullness behind. Above the clavicle there was harsh breathing with prolonged blowing expiration. Below there was roughened inspiration. In the right supra-scapular area, corresponding to the dullness was roughened inspiration and blowing expiration. In the inter-scapular area on both sides there was a fine crepitant shower at the end of deep inspiration. She brought up a small amount of muco-purulent sputum, which showed no tubercle bacilli, even with the Ellermann and Erlandsen technic. There were no eosinophiles in the cellular content of her sputum, but 85 per cent. of them were lymphocytes. She reacted mildly and slowly to a cutaneous tuberculin test, the maximum appearing at the end of seventy-two hours; just such a reaction as one sees in the average healthy adult.

Correlating the history, symptomatology, and physical signs of this patient, what of the diagnosis? Shall we content ourselves with the verdict "not proven"? Must we wait for the presence of bacilli? Open tuberculosis is rarely early tuberculosis; and by early tuberculosis I mean that stage of the disease presenting reasonable hope of an arrestment of the process by proper treatment. We are not speaking of incipient tuberculosis, a term which has no justification for its existence in considering the disease in adults. This statement may seem revolutionary, and yet I venture to prophesy that when it is generally recognized that tuberculosis obtains foothold first in infancy or early childhood, and when the pathology and the methods by which it spreads are more thoroughly understood, the term "incipient" will not have the prominent place in medical nomenclature it now possesses. There will then be a general recognition of the fact that true incipiency in lung tuberculosis at least is not clinically demonstrable.

In infancy or early childhood, bacilli, gaining entrance before specific resistance has been built up, may find lodgment in almost any of the tissues of the body, because at this time there is no selective affinity of tissue for the tubercle bacillus. Hence the incidence of tuberculosis in meninges, bones, joints, peritoneum, and other tissues. Bacilli finding their way to lymphatic glands, however, are more apt to be held in check, because of the anti-bacillary action of the lymph elements and may thus never give rise to symptoms. This phenomenon is familiar to us all in the chronic tuberculosis infections of the superficial neck glands in children. Yet tuberculous infection has inevitably taken place and cell sensitization occurs, an important part of the partial immunity produced and enjoyed by mankind generally. This cell sensitization was abundantly proven by Koch's inoculation experiment, and explains the tuberculin skin reaction obtained generally in older children and in adults.

At what time, and in what manner does this tuberculous infection become clinically demonstrable? While in early life bacilli escaping from lymph glands may be implanted in any portion of the body, in later life lung tissue presents selective affinity. Whether metastases occur through the blood or lymph stream or both does not here concern us. The early metastases may escape observation because the bacilli escaping into the blood stream are few, their virulence is inhibited by the anti-bacterial elements already formed in the blood, and the specific resistance set up by

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